DELTA DENTAL

DeltaCare

Please read the following information so you will know from whom or what group of provider dental care may be obtained.

AN ECONOMICAL APPROACH TO DENTAL CARE

In an age of rising health care costs, Delta Dental of Virginia ("Delta Dental") offers an alternative way to provide for you and your family's dental care needs - economically and conveniently through the DeltaCare program. This program was founded on the principle of delivering quality dental care and preventing dental problems before they start.

Delta Dental has contracted with a network of private dentists. A listing of these dentists is enclosed. As an enrollee in the DeltaCare program you select a dentist from the DeltaCare panel dentist listing for your family. This network of DeltaCare dentists is composed of established dental practices. Once enrolled, you can change your DeltaCare panel dentist during your Group's annual enrollment period. You may also change your DeltaCare panel dentist between your annual enrollment period, if you are not satisfied with your DeltaCare panel dentist, his/her office is no longer convenient or your family status changes. You must notify Delta Dental in writing before the 15th of the month if you wish the change to be effective on the 1st of the next month.

■ ADVANTAGES

No Claim Forms for Most Services
The DeltaCare panel dentist you select provides all your general dental services. Generally, there are no claim forms to complete and you do not have to pay a percentage of the dentist's usual charges.

No Deductibles
In the DeltaCare program there are no required deductibles to pay so your benefits begin immediately.

No Dollar Limit of Dental Benefits
No annual benefit maximum for dental services provided by your DeltaCare dentist.

No Pre-Existing Conditions Restricted
Pre-existing conditions are not excluded in the DeltaCare program, this means you can begin receiving services immediately. **One Exception:** Work in progress. Some dental services require multiple visits. If a service is started prior to enrolling, it is considered work in progress. Examples of work in progress include: orthodontics, root canal therapy, crowns and bridges.

Prepaid Plan Saves on Dental Costs
Your out-of-pocket savings are substantial. You know prior to treatment exactly what you will have to pay. This aids in better fiscal planning for you and your family.

Quality Review of Dental Providers
Delta Dental will conduct on-site audits of DeltaCare dentists to insure that established standards of quality are maintained.

Specialty Services
The DeltaCare program offers services in dental specialty areas. These include periodontics (treatment of diseased gums and bone), endodontics (root canal therapy), and oral surgery procedures. Written referral is generally required.

Remember to always contact your selected DeltaCare dentist for all your dental needs. **NOTE: Dental services you receive which are not performed by your DeltaCare panel dentist or specialist services received without prior authorization by Delta Dental are not covered by the DeltaCare program.**

■ EMERGENCY SERVICES

You are also covered for out-of-area dental emergencies. "Out-Of-Area" means you are in need of covered dental services and you are 35 miles from your DeltaCare dentist's office. **Note:** A benefit maximum does apply to emergency services.

■ HOW IT WORKS

When you enroll in DeltaCare, select a dentist that participates in the DeltaCare program from the list in this brochure. This dentist is now the center for all of your dental needs.

After you have enrolled, you will receive an Evidence of Coverage booklet that fully describes the benefits of your dental plan as well as a DeltaCare membership card. To receive all necessary care covered by the plan, simply call your selected panel dentist to make an appointment.

■ WHO CAN JOIN

If you meet the employer's eligibility guidelines for dental coverage you can enroll in DeltaCare. You can also enroll your eligible dependents, which include your lawful spouse and unmarried children; including step-children and legally adopted children.

■ SUMMARY OF BENEFITS

The DeltaCare program covers all reasonable and customary dental care (subject to the contract provisions, limitation and exclusions), provided care is rendered by your assigned DeltaCare dentist. Except for co-payments on certain procedures, there is no cost for covered services to the primary enrollee or eligible dependent enrollee. (See Schedule A for Description of Benefits and Co-payments.)

LIMITATIONS AND EXCLUSIONS OF BENEFITS

LIMITATIONS

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy);
2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
4. Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
5. Denture relines are limited to one per denture during any 12 consecutive months;
6. Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months;
7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
8. Bitewing x-rays are limited to not more than one series of four films in any six month period;
9. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
10. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits include the repair or replacement of a sealant on any tooth within three years of its application by the same DeltaCare Dentist who placed the sealant.
11. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
12. Coverage is limited to the benefit customarily provided. Enrollee must pay the difference in cost between the Dentist's usual fees for the Covered Benefit and the optional or more expensive treatment plus any applicable Copayment;
13. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial to restore a missing tooth, are considered optional treatment;
14. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids;
15. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement;
16. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
17. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned DeltaCare Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Delta Dental will consider exceptions for medical conditions, regardless of age limitation, on an individual basis.
18. Porcelain crowns and porcelain fused to metal crowns on all molars are considered Optional Treatment;
19. Fixed bridges used to replace missing posterior teeth are considered Optional Treatment when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the DeltaCare Dentist's Plan Allowance for the Covered Benefit and the Optional Treatment, plus any Copayment for the Covered Benefit.

EXCLUSIONS

The following are not Covered Benefits under any circumstance **unless specifically identified** as a Covered Benefit in the **Schedule A - Description of Benefits and Copayments**:

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
2. Dental procedures performed for purely cosmetic purposes;
3. Dental Services for injuries or conditions that may be covered under Worker's Compensation or similar employer liability laws; benefits or services that are available under any federal, state, or municipal government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity; also services provided to the Enrollee without cost by any municipality, county or other political subdivision;
4. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility;
5. Treatment of fractures, dislocations and subluxations of the upper or lower jaw. This includes therapy, surgery and appliances to correct temporomandibular joint (TMJ) dysfunction, problems, and/or occlusal disharmony (including occlusal equilibration).

6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
7. Dental Services started or provided before the date the Enrollee is enrolled under the EOC. Also, except as otherwise provided in this EOC, benefits for a course of treatment that began before the Enrollee is enrolled under this EOC.
8. Except as otherwise provided in this EOC, Dental Services provided after the date that the individual is no longer enrolled or eligible for coverage under this EOC.
9. Any service not specifically listed as a Covered Benefit in **Schedule A - Description of Benefits and Copayments**;
10. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law);
11. Cysts and malignancies;
12. Prescription drugs;
13. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits **subject to this EOC's terms, conditions, limitations, and other exclusions**;
14. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
15. Dental services received from any dental office other than the assigned DeltaCare dental office, unless expressly authorized in writing by Delta Dental or as cited under 'Emergency Service';
16. Prophylactic removal of impactions (asymptomatic, nonpathological);
17. "Consultations" for noncovered benefits;
18. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
19. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
20. Porcelain crowns and porcelain fused to metal crowns on all molars;
21. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
22. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The patient must pay the difference in cost between the Dentist's usual fees for the covered benefit and plan allowance for the optional treatment, plus any Copayment for the Covered Benefit;
23. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnatholgic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ);
24. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
25. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
26. Soft tissue management including without limitation irrigation, infusion, and any special toothbrush;
27. Diagnosis, treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
28. Restorative work caused by orthodontic treatment;
29. Extractions solely for the purpose of orthodontics; and
30. Specialist Services that Delta Dental has not authorized in writing in advance (except Covered Benefits for orthodontic services that a DeltaCare Orthodontist provides).

ORTHODONTIC LIMITATIONS

The DeltaCare dental plan provides coverage for orthodontic treatment plans provided by a DeltaCare Orthodontist. The cost to the Enrollee for the treatment plan is listed in **Schedule A - Description of Benefits and Copayments** subject to the following:

1. Orthodontic treatment must be provided by a DeltaCare Orthodontist.
2. Plan benefits cover 24 months of active comprehensive orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months.
3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed $75 per month.
4. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination, the Enrollee or Enrollee's dependent is receiving orthodontic treatment, the Enrollee and not Delta Dental will be solely responsible for payment for treatment provided after cancellation or termination. In such a case, the Enrollee's payment shall be based on the Dentist's usual fee at the beginning of treatment. The amount will be pro-rated over the

months until completion of the treatment and will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Orthodontist.

5. If treatment is not required or the Enrollee chooses not to start treatment after the Orthodontist has completed the diagnosis and consultation, the Enrollee will be charged a consultation fee of $25 in addition to diagnostic record fees.
6. The Copayment is payable to the DeltaCare Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another DeltaCare Orthodontist to continue orthodontic treatment the Enrollee will not be entitled to a refund of any amounts previously paid. In addition, the Enrollee will be responsible for all payments, up to and including the full Copayment, that is required by the new DeltaCare Orthodontist for completion of the orthodontic treatment.
7. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Covered Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the DeltaCare Orthodontist's Plan Allowance.

EXCLUSIONS [ORTHODONTIC]

The following are not Covered Benefits under any circumstance **unless specifically identified** as a Covered Benefit in the **Schedule A - Description of Benefits and Copayments**:

1. Orthodontic services provided by an Orthodontist who is not a DeltaCare Orthodontist;
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
3. Retreatment of orthodontic cases;
4. Changes in treatment necessitated by accident of any kind;
5. Surgical procedures incidental to orthodontic treatment;
6. Myofunctional therapy;
7. Surgical procedures related to cleft palate, micrognathia or macrognathia;
8. Treatment related to temporomandibular joint disturbances (TMJ);
9. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst;
10. Restorative work caused by orthodontic treatment;
11. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month;
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition;
13. Extractions solely for the purpose of orthodontics;
14. Treatment in progress at inception of eligibility;
15. Patient initiated transfer after bands have been placed;
16. Composite or ceramic brackets, lingual adaption of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

HOW TO ENROLL:

Once you decide to enroll, complete the enrollment form and indicate your dentist of choice from the panel list enclosed. Return the form to your employer as directed by your Human Resources Department.

If you have any questions or need additional information call or write:

Delta Dental of Virginia
ATTN: DeltaCare
4818 Starkey Road
Roanoke, VA 24018
(800) 862-0838
Office Hours M-F: 8:15-4:45 EST

NOTE: THIS IS ONLY A BRIEF DESCRIPTION OF THE PLAN.
The dental health plan contract (GrpCont.POD#12.2006) must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage booklet will be sent to you upon enrollment.

DELTACARE – PLAN 4B

SCHEDULE A - DESCRIPTION OF BENEFITS AND COPAYMENTS (FIXED DOLLAR COPAYMENT)

The benefits shown below are performed as deemed appropriate by the attending DeltaCare Dentist subject to the limitations and exclusions of the program. Please refer to the Limitations and Exclusions for further clarification of benefits.

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and are not to be interpreted as American Dental Association (ADA) current dental terminology (CDT) procedure codes, descriptors or nomenclature that are under copyright by the ADA. The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal regulations.

CODES

I.	DIAGNOSTIC	COPAYMENT
D0120	Periodic oral evaluation-established patient	No Cost
D0140	Limited oral evaluation—problem focused	No Cost (GP)*
D0140	Limited oral evaluation—problem focused	$30.00 (SP)*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation – new or established patient	No Cost (GP)*
D0150	Comprehensive oral evaluation – new or established patient	$30.00 (SP)*
D0160	Detailed and extensive oral evaluation—problem focused, by report	No Cost (GP)*
D0160	Detailed and extensive oral evaluation—problem focused, by report	$30.00 (SP)*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive Periodontal Evaluation – new or established patient	No Cost (GP)*
D0180	Comprehensive Periodontal Evaluation – new or established patient	$30.00 (SP)*
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral—complete series of radiographic images	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings - three radiographic images	No Cost
D0274	Bitewings - four radiographic images	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0999	Unspecified diagnostic procedure, by report – *includes office visit, per visit (in addition to other services)*	$5.00

* GP – General Practitioner
SP – Specialty Practitioner

II.	PREVENTIVE	
D1110	Prophylaxis *cleaning* – adult – *1 per 6 month period*	No Cost
D1120	Prophylaxis *cleaning* – child – *1 per 6 month period*	No Cost
D1206	Topical application of fluoride varnish – child *(to age 19) – 1 per 6 month period*	No Cost
D1208	Topical application of fluoride – child *(to age 19) – 1 per 6 month period*	No Cost
D1330	Oral hygiene instructions	No Cost

CODES		COPAYMENT
D1351	Sealant, per tooth limited to permanent molars through age 15	$12.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth - *limited to permanent molars through age 15*	$12.00
D1510	Space maintainer—fixed—unilateral	$66.00
D1515	Space maintainer—fixed—bilateral	$66.00
D1520	Space maintainer—removable—unilateral	$66.00
D1525	Space maintainer—removable—bilateral	$66.00
D1550	Recementation of space maintainer	$12.00
D1555	Removal of fixed space maintainer	$12.00

III. RESTORATIVE (Fillings)

Includes indirect pulp capping, bases, liners and acid etch procedures

D2140	Amalgam—one surface, primary or permanent	$24.00
D2150	Amalgam—two surfaces, primary or permanent	$26.00
D2160	Amalgam—three surfaces, primary or permanent	$29.00
D2161	Amalgam—four or more surfaces, primary or permanent	$31.00
D2330	Resin—based composite—one surface, anterior	$25.00
D2331	Resin—based composite—two surfaces, anterior	$31.00
D2332	Resin—based composite—three surfaces, anterior	$36.00
D2335	Resin—based composite—four or more surfaces or involving incisal angle (anterior)	$42.00
D2390	Resin-based composite crown, anterior	$66.00
D2391	Resin-based composite - one surface, posterior	Optional
D2392	Resin-based composite - two surfaces, posterior	Optional
D2393	Resin-based composite - three surfaces, posterior	Optional
D2394	Resin-based composite - four or more surfaces, posterior	Optional
D2410	Gold foil—one surface	Optional
D2420	Gold foil—two surfaces	Optional
D2430	Gold foil—three surfaces	Optional
D2510	Inlay—metallic—one surface	$190.00
D2520	Inlay—metallic—two surfaces	$200.00
D2530	Inlay—metallic—three or more surfaces	$210.00
D2542	Onlay—metallic—two surfaces	$208.00
D2543	Onlay—metallic—three surfaces	$218.00
D2544	Onlay—metallic—four or more surfaces	$226.00
D2610	Inlay—porcelain/ceramic—one surface	Optional
D2620	Inlay—porcelain/ceramic—two surfaces	Optional
D2630	Inlay—porcelain/ceramic—three or more surfaces	Optional
D2642	Onlay—porcelain/ceramic—two surfaces	Optional
D2643	Onlay—porcelain/ceramic—three surfaces	Optional
D2644	Onlay—porcelain/ceramic—four or more surfaces	Optional
D2650	Inlay—resin-based composite composite/resin—one surface	Optional
D2651	Inlay—resin-based composite composite/resin—two surfaces	Optional
D2652	Inlay—resin-based composite composite/resin—three or more surfaces	Optional
D2662	Onlay—composite/resin—two surfaces	Optional
D2663	Onlay—composite/resin—three surfaces	Optional
D2664	Onlay—composite/resin—four or more surfaces	Optional
D2710	Crown—resin-based composite (indirect) [†]	$144.00
D2720	Crown—resin with high noble metal [*][†]	$270.00
D2721	Crown—resin with predominately base metal [†]	$270.00
D2722	Crown—resin with noble metal [†]	$270.00
D2740	Crown—porcelain /ceramic substrate [†]	$270.00
D2750	Crown—porcelain fused to high noble metal [*][†]	$270.00
D2751	Crown—porcelain fused to predominately base metal [†]	$270.00
D2752	Crown—porcelain fused to noble metal [†]	$270.00
D2780	Crown—¾ cast high noble metal [*]	$270.00
D2781	Crown—¾ cast predominately base metal	$270.00
D2782	Crown—¾ cast noble metal	$270.00
D2783	Crown—¾ cast porcelain/ceramic [†]	$270.00
D2790	Crown—full cast high noble metal	$270.00

CODES		COPAYMENT
D2791	Crown—full cast predominately base metal	$270.00
D2792	Crown—full cast noble metal	$270.00
D2794	Crown—titanium [*]	$270.00
D2910	Recement inlay, onlay or partial coverage restoration	$12.00
D2915	Recement cast or prefabricated post and core	$12.00
D2920	Recement crown	$12.00
D2929	Prefabricated porcelain/ceramic crown - anterior primary tooth	Optional
D2930	Prefabricated stainless steel crown—primary tooth	$66.00
D2931	Prefabricated stainless steel crown—permanent tooth	$66.00
D2932	Prefabricated resin crown - anterior teeth only	$66.00
D2933	Prefabricated stainless steel crown with resin window	Optional
D2940	Protective restoration	$19.00
D2950	Core buildup, including any pins	$24.00
D2951	Pin retention—per tooth, in addition to restoration	$24.00
D2952	Post and core in addition to crown, indirectly fabricated [*]	$24.00
D2953	Each additional indirectly fabricated post—same tooth [*]	$24.00
D2954	Prefabricated post and core in addition to crown	$24.00
D2957	Each additional prefabricated post—same tooth	$24.00
D2970	Temporary crown (fractured tooth)	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework	$55.00
D2980	Crown repair necessitated by restorative material failure	$20.00+lab
D2981	Inlay repair necessitated by restorative material failure	$20.00+lab
D2982	Onlay repair necessitated by restorative material failure	$20.00+lab
D2990	Resin infiltration of incipient smooth surface lesions *- limited to permanent molars through age 15*	$12.00

IV. ENDODONTICS

D3110	Pulp cap—direct (excluding final restoration)	No Cost
D3120	Pulp cap—indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament	$19.00
D3221	Pulpal debridement, primary and permanent teeth	$18.00
D3222	Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development	$19.00
D3230	Pulpal therapy (resorbable filling) —anterior, primary tooth (excluding final restoration)	$19.00
D3240	Pulpal therapy (resorbable filling) —posterior, primary tooth (excluding final restoration)	$19.00
D3310	Root canal—anterior (excluding final restoration)	$72.00
D3320	Root canal—bicuspid (excluding final restoration)	$144.00
D3330	Root canal—molar (excluding final restoration)	$216.00
D3331	Treatment of root canal obstruction; non-surgical access	$72.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$72.00
D3346	Retreatment of previous root canal therapy—anterior	$87.00
D3347	Retreatment of previous root canal therapy—bicuspid	$172.00
D3348	Retreatment of previous root canal therapy—molar	$260.00
D3410	Apicoectomy/periradicular surgery—anterior	$120.00
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)	$120.00
D3425	Apicoectomy/periradicular surgery—molar (first root)	$120.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$60.00
D3430	Retrograde filling - per root	$60.00

V. PERIODONTICS

Includes preoperative and postoperative evaluations and treatment under a local anesthetic

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces, per quadrant	$210.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces, per quadrant	$210.00

CODES		COPAYMENT
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$210.00
D4240	Gingival flap procedures, including root planing - four or more contiguous teeth or bounded teeth spaces, per quadrant	$180.00
D4241	Gingival flap procedures, including root planing - one to three contiguous teeth or bounded teeth spaces, per quadrant	$180.00
D4245	Apically positioned flap	$180.00
D4249	Clinical crown lengthening—hard tissue	$175.00
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces, per quadrant	$360.00
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces, per quadrant	$360.00
D4341	Periodontal scaling and root planing – four or more teeth, per quadrant	$54.00
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$54.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$54.00
D4910	Periodontal maintenance	$44.00
VI.	**PROSTHODONTICS, (removable)**	
D5110	Complete denture—maxillary [**]	$300.00
D5120	Complete denture—mandibular [**]	$300.00
D5130	Immediate denture—maxillary [**]	$384.00
D5140	Immediate denture—mandibular [**]	$384.00
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth) [**]	$329.00
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth) [**]	$329.00
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [**]	$354.00
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [**]	$354.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth) [**]	Optional
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth) [**]	Optional
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$329.00
D5410	Adjust complete denture—maxillary	$12.00
D5411	Adjust complete denture—mandibular	$12.00
D5421	Adjust partial denture—maxillary	$12.00
D5422	Adjust partial denture—mandibular	$12.00
D5510	Repair broken complete denture base	$30.00
D5520	Replace missing or broken teeth—complete denture (each tooth)	$12.00
D5610	Repair resin denture base	$30.00
D5620	Repair cast framework	$30.00
D5630	Repair or replace broken clasp	$30.00
D5640	Replace broken teeth - per tooth	$12.00
D5650	Add tooth to existing partial denture	$12.00
D5660	Add clasp to existing partial denture	$12.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$185.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$185.00
D5710	Rebase complete maxillary denture	$60.00
D5711	Rebase complete mandibular denture	$60.00
D5720	Rebase maxillary partial denture	$60.00
D5721	Rebase mandibular partial denture	$60.00
D5730	Reline complete maxillary denture (chairside)	$36.00
D5731	Reline complete mandibular denture (chairside)	$36.00
D5740	Reline maxillary partial denture (chairside)	$36.00
D5741	Reline mandibular partial denture (chairside)	$36.00
D5750	Reline complete maxillary denture (laboratory)	$60.00
D5751	Reline complete mandibular denture (laboratory)	$60.00
D5760	Reline maxillary partial denture (laboratory)	$60.00
D5761	Reline mandibular partial denture (laboratory)	$60.00

CODES		COPAYMENT
D5820	Interim partial denture (maxillary)	$30.00
D5821	Interim partial denture (mandibular)	$30.00
D5850	Tissue conditioning, maxillary	$30.00
D5851	Tissue conditioning, mandibular	$30.00
D5860	Overdenture—complete, by report	Optional
D5861	Overdenture—partial, by report	Optional

** *Includes any adjustment for six (6) months*

VII. MAXILLOFACIAL PROSTHETICS – NOT COVERED (D5900-D5999)

VIII. IMPLANT SERVICES – NOT COVERED (D6000-D6199)

IX.PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in fixed partial denture [bridge])

D6210	Pontic—cast high noble metal [*]	$270.00
D6211	Pontic—cast predominantly base metal	$270.00
D6212	Pontic—cast noble metal	$270.00
D6240	Pontic—porcelain fused to high noble metal [*][†]	$270.00
D6241	Pontic—porcelain fused to predominantly base metal [†]	$270.00
D6242	Pontic—porcelain fused to noble metal [†]	$270.00
D6250	Pontic—resin with high noble metal [*][†]	$270.00
D6251	Pontic—resin with predominantly base metal [†]	$270.00
D6252	Pontic—resin with noble metal [†]	$270.00
D6545	Retainer—cast metal for resin bonded fixed prosthesis	Optional
D6548	Retainer—porcelain/ceramic for resin bonded fixed prosthesis	Optional
D6600	Inlay—porcelain/ceramic, two surfaces	Optional
D6601	Inlay—porcelain/ceramic, three or more surfaces	Optional
D6602	Inlay—cast high noble metal, two surfaces [*]	$210.00
D6603	Inlay—cast high noble metal, three or more surfaces [*]	$210.00
D6604	Inlay—cast predominantly base metal, two surfaces	$190.00
D6605	Inlay—cast predominately base metal, three or more surfaces	$200.00
D6606	Inlay—Inlay cast noble metal, two surfaces	$200.00
D6607	Inlay - cast noble metal, three or more surfaces	$210.00
D6608	Onlay – porcelain/ceramic, two surfaces	Optional
D6609	Onlay – porcelain/ceramic, three or more surfaces	Optional
D6610	Onlay – cast high noble metal, two surfaces [*]	$218.00
D6611	Onlay – cast high noble metal, three or more surfaces [*]	$226.00
D6612	Onlay – cast predominantly base metal, two surfaces	$208.00
D6613	Onlay – cast predominantly base metal, three or more surfaces	$216.00
D6614	Onlay – cast noble metal, two surfaces	$218.00
D6615	Onlay – cast noble metal, three or more surfaces	$226.00
D6720	Crown—resin with high noble metal [*][†]	$270.00
D6721	Crown—resin with predominantly base metal [†]	$270.00
D6722	Crown—resin with noble metal [†]	$270.00
D6750	Crown—porcelain fused to high noble metal [*][†]	$270.00
D6751	Crown—porcelain fused to predominantly base metal [†]	$270.00
D6752	Crown—porcelain fused to noble metal [†]	$270.00
D6780	Crown—¾ cast high noble metal [*]	$270.00
D6781	Crown—¾ cast predominantly base metal	$270.00
D6782	Crown—¾ cast noble metal	$270.00
D6790	Crown—full cast high noble metal [*]	$270.00
D6791	Crown—full cast predominantly base metal	$270.00
D6792	Crown—full cast noble metal	$270.00
D6930	Recement fixed partial denture	$18.00
D6940	Stress breaker	$42.00

**Base or noble metal is the Covered Benefit. If high noble metal (precious) is used for a crown, bridge, cast post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the high noble metal. An additional laboratory charge also applies to a titanium crown.*
†Porcelain on molars is considered optional treatment.

CODES		COPAYMENT
X.	**ORAL AND MAXILLOFACIAL SURGERY** *Includes preoperative and postoperative evaluations and treatment under local anesthetic*	
D7111	Extraction, coronal remnants – deciduous teeth	$22.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal); includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	$22.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$36.00
D7220	Removal of impacted tooth—soft tissue	$60.00
D7230	Removal of impacted tooth—partially bony	$90.00
D7240	Removal of impacted tooth—completely bony	$120.00
D7241	Removal of impacted tooth—completely bony, with unusual surgical complications	$120.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$42.00
D7251	Coronectomy – internal partial tooth removal	$120.00
D7286	Biopsy of oral tissue—soft	$30.00
D7310	Alveoloplasty in conjunction with extractions, four or more teeth or tooth spaces - per quadrant	$78.00
D7311	Alveoloplasty in conjunction with extractions, one to three teeth or tooth spaces - per quadrant	$78.00
D7320	Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per quadrant	$102.00
D7321	Alveoloplasty not in conjunction with extractions, one to three teeth or tooth spaces - per quadrant	$102.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$78.00
D7472	Removal of torus palatinus	$78.00
D7473	Removal of torus mandibularis	$78.00
D7510	Incision and drainage of abscess—intraoral soft tissue	$25.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure not incidental to another procedure	$60.00
XI.	**ORTHODONTICS** *Records solely for the purpose of Orthodontics include pre- and post records as follows:*	
Pre-records include the following:		$200.00
D0210	Intraoral—complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	Cephalometric radiographic image	
D0350	Oral/facial photographic images	
D0470	Diagnostic casts	
Post-records include the following:		$70.00
D0210	Intraoral—complete series of radiographic images	
D0470	Diagnostic casts	
D8020	Limited orthodontic treatment of the transitional dentition [***]	$1,950.00
D8030	Limited orthodontic treatment of the adolescent dentition [***]	$1,950.00
D8040	Limited orthodontic treatment of the adult dentition [***]	$2,350.00
D8070	Comprehensive orthodontic treatment of the transitional dentition [***]	$2,150.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition [***]	$1,950.00
D8090	Comprehensive orthodontic treatment of the adult dentition [***]	$2,350.00
D8660	Pre-orthodontic treatment visit (applied to treatment fee if patient proceeds with treatment)	$25.00
D8670	Periodic orthodontic treatment visit (as part of contract)	Inclusive of treatment fee
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [***]	No Cost

CODES **COPAYMENT**

***Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. For treatment plans extending beyond 24 months of active treatment, the Subscriber will be subject to a monthly office fee, not to exceed $75 per month.

XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain-minor procedure	$18.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9310	Consultation - diagnostic services provided by a dentist or physician other than requesting dentist or physician	$30.00
D9440	Office visit - after regularly scheduled hours	$24.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9999	Unspecified adjunctive procedure, by report – includes failed appointment without 24-hour notice - per 15 minutes of appointment time	$10.00

Optional is defined as any alternative procedure presented by the DeltaCare Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the dental plan. The applicable charge to the Enrollee is the difference between the DeltaCare dentist's fee for the Optional procedure and the Plan Allowance for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. Questions regarding the DeltaCare dental plan should be directed to DeltaCare's Benefit Service department at (800) 862-0838. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial to restore a missing tooth are considered optional treatment. The patient must pay the difference in cost between the dentist's usual fees for the Covered Benefit and the optional or more expensive treatment plus any applicable Copayment.

If services for a listed procedure are performed by the assigned DeltaCare Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned DeltaCare Dentist, must be preauthorized in writing by Delta Dental of Virginia. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered; however, may be available at the DeltaCare Dentist's Plan Allowance.

The above procedures are performed as needed and deemed necessary by your attending DeltaCare Dentist subject to the limitations and exclusions of the program. Please refer to those sections for further clarification of benefits.

The DeltaCare Dentist shall provide emergency dental care for a Covered Benefit which is required while an Enrollee is within 35 miles of the facility of the DeltaCare Dentist. If a Enrollee requires emergency dental care and is more than 35 miles from the facility of the DeltaCare Dentist, then Delta Dental of Virginia shall reimburse the Enrollee the cost of such emergency dental care which exceeds the Enrollee's Copayment up to a $50 maximum in a 12-month period. Emergency dental care shall be limited to listed procedures, and as described in code D9110 above: "Palliative (emergency) treatment of dental pain". Any further treatment of the cause of such emergency dental care must be preauthorized by Delta Dental or provided by the assigned DeltaCare Dentist.